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ABSTRACT

This report discusses the health care needs of and benefits for women, children, and adolescents in light of national health care reform proposals put forth in 1994, and is based on presentations and discussions at an invitational workshop on maternal and child health. The report asserts that since women and children are disproportionately represented among the uninsured, expanding health insurance coverage to this group will also increase their access to health services more than expansion will help other groups. Adequate support is also needed for the public health and community services that many maternal and child health programs promote. Women in their childbearing years need a wide variety of reproductive health services in addition to routine medical care and mental health services. The report argues that continued efforts to design a comprehensive benefits package for women and children in the context of health care reform needs to be pursued. Neither the current system for delivering traditional personal health services nor the public health system alone can effectively provide the full range of health services needed by women and children. An appendix provides a list of workshop participants. (Contains 23 references.) (MDM)

Benefits and Systems of Care for Maternal and Child Health Under Health Care Reform

Workshop Highlights

Committee on
Maternal and Child Health Under Health Care Reform

Cynthia H. Abel, Editor

Board on Health Promotion and Disease Prevention
Institute of Medicine

and

Board on Children and Families
Commission on Behavioral and Social Sciences and Education
National Research Council / Institute of Medicine

NATIONAL RESEARCH COUNCIL
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This report has been reviewed by a group other than the authors according to procedures approved by a Report Review Committee consisting of members of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.

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Preface

This report is based on presentations and discussions at an invitational workshop on Maternal and Child Health Under Health Care Reform held on July 7-8, 1994, in Washington, D.C. The workshop was organized by the Board of Health Promotion and Disease Prevention of the Institute of Medicine (IOM) and the Board on Children and Families, which operates under the joint auspices of the IOM and the Commission on Behavioral and Social Sciences and Education of the National Research Council (NRC). A steering committee (see committee roster, p. iii) was appointed to oversee the workshop and the preparation of resulting reports, including this report. These reports do not present formal recommendations. Funding for this project was provided by the March of Dimes Birth Defects Foundation, the National Foundation for Public Health Policy, and the U.S. Department of Health and Human Services through the Maternal and Child Health Bureau and the Office of the Assistant Secretary for Health.

A long-standing interest in the health and well-being of mothers and children led the IOM and the NRC to convene this workshop to examine the specific needs of this population in the context of health care reform. This report is based on the views presented and opinions discussed during the first day of the workshop, which focused on benefits and systems of care for mothers and children. The second day of the workshop focused primarily on quality improvement and performance monitoring for children's health care services. Speakers and participants included health care and public health professionals involved in the delivery of services, research, and policy development; representatives of federal agencies; and congressional staff. A list of participants appears in the Appendix.

Because of the rapidly changing legislative picture at the time of the workshop, a systematic comparison of the provisions of the various reform proposals being debated in congressional committees was not attempted. Underlying most of the presentations and discussion, however, was a general assumption that changes were already occurring in the health care system that would lead to further growth of managed care and integrated health systems regardless of federal legislative action.

Since the workshop, Congress has chosen not to pursue health care reform legislation during the 103rd Congress, but health care may be considered again in 1995. Because the passage of legislation for universal health insurance coverage remains uncertain, there is an effort to draft legislation that would extend health insurance coverage to all children and women of reproductive age, and much of the discussion at the workshop was relevant to the evaluation of such a proposal. In addition, health care reform activities already underway in many states and the issues discussed at the workshop are also relevant to those states' efforts to extend coverage, and should be considered by federal agencies considering waivers of federal laws necessary to implement state reforms.

Several people were particularly helpful to the staff in formulating the workshop agenda and identifying possible speakers: Donald Berwick, Institute for Health Care Improvement; Amy Fine, Association of Maternal and Child Health Programs; Neal Halfon, UCLA School of Public Health; Kay Johnson, March of Dimes Birth Defects Foundation; Woodie Kessel, Maternal and Child Health Bureau; Jonathan Kotch, National Foundation for Public Health Policy; Kristen Langlykke and Pamela Mangu, National Center for Education in Maternal and Child Health; Sara Rosenbaum and Elizabeth Wehr, the George Washington University Center for Health Policy Research; and Lisa Simpson and Robert Valdez, Office of the Assistant Secretary for Health. The comments received from formally designated reviewers helped refine and strengthen the report.

Numerous staff members in addition to those listed with the workshop steering committee contributed to the success of the workshop and the preparation of this report: Brenda Buchbinder, Claudia Carl, Nancy Crowell, Molla Donaldson, Judith Doody, Michael Edington, Marilyn Field, Eugenia Grohman, Carrie Ingalls, Amanda Klekowski, Kathleen Lohr, Philomina Mammen, Alison Smith, and Mary Thomas.

Contents

SUMMARY 1

INTRODUCTION 2

HEALTH CARE NEEDS OF WOMEN, CHILDREN, AND ADOLESCENTS 4
- Health Care Needs of Women 4
- Health Care Needs of Children 5
- Health Care Needs of Adolescents 6

HEALTH CARE BENEFITS FOR WOMEN AND CHILDREN 6
- Defining Medical Necessity 7

COORDINATED HEALTH CARE SERVICES FOR WOMEN AND CHILDREN 8
- Access to Health Care 8
  - Managed-Care Organizations 9
- Public Programs for Maternal and Child Health 9

CONCLUSION 11

REFERENCES 12

APPENDIX 14

Benefits and Systems of Care for Maternal and Child Health Under Health Care Reform: Workshop Highlights

SUMMARY

In the summer of 1994, Congress was in the midst of debating legislation to reform the health care system. Congress chose not to pursue health care reform legislation this year, but plans to consider it again next year. If Congress does enact health care reform legislation next year, it could change the way health care is financed and delivered in the United States. All Americans have health care needs that will have to be met, but the current interest in health care reform, coupled with the long-standing interest of the Institute of Medicine (IOM) and the National Research Council (NRC) in the well-being of women and children, presented a special opportunity to address the unique health care requirements of women in their childbearing years, children, and adolescents. This report is based on a July 1994 workshop organized by the IOM and the NRC, which focused on health care benefits and systems of care for maternal and child health under health care reform.

Because women and children are disproportionately represented among the uninsured, expanding health insurance coverage to this group will also increase their access to necessary health services more than other groups. Workshop discussions emphasized, however, that neither health insurance coverage nor better benefits will meet all of the health care needs of women and children. Adequate support is also needed for the public health and community services that many maternal and child health programs promote. The public health system (comprising federal, state, and local health departments) provides essential, population-based public health services such as surveillance and vital statistics, epidemic control, and environmental monitoring. In addition, state and local public health departments often provide personal health services such as prenatal care and well-child care, and enabling services such as case management, transportation, and home visiting.

Workshop discussions highlighted the need that women in their childbearing years (and especially women who are pregnant) have for a wide variety of reproductive health services in addition to routine medical care and mental health services. Participants agreed that health care services for women should include contraceptive services and supplies; diagnosis and treatment of sexually transmitted diseases; prenatal, intrapartum, and postpartum care; regular breast and pelvic exams (including Pap tests), in accordance with well-recognized periodicity schedules;

risk assessment; and adequate education and counselling to support all of these interventions. Participants also outlined children's health care needs, which vary at different ages. Although most children are fundamentally healthy, they require health care that emphasizes preventive services, such as immunizations, and the monitoring of physical and psychosocial growth and development, with particular attention to critical periods in which appropriate care is essential for sound development and progress. Adolescents require access not only to medical care for illness and injury but also to family planning services, mental health services, substance abuse treatment, anticipatory guidance, and various informational and educational activities that are oriented toward the development of positive health behaviors. Some of their health problems arise from health-damaging behaviors that increase their risks for sexually transmitted diseases, unintended pregnancy, substance abuse, injuries, and violence. Intervening during adolescence provides an opportunity to prevent the onset of health-damaging behavior as well as to introduce and establish healthy new behavior patterns that may span a lifetime.

Workshop participants pointed out that there should be continued efforts to design a comprehensive benefits package for women and children in the context of health care reform. The discussion of health care benefits for women and children emphasized a need for more attention to family planning services, mental health and substance abuse services, and services for children with special health care needs. Several approaches to benefit design were addressed by workshop participants, including benefit packages from several congressional health care reform proposals, without attempting to reach consensus.

Neither the current system for delivering traditional personal health services nor the public health system alone can effectively provide the full range of health services needed by women and children. Consequently, many people feel that a collaboration between the public health system and providers of personal health services is necessary to ensure access to comprehensive health care for these groups. Participants in the workshop agreed that many old models for health care delivery are no longer adequate and that health care reform needs to promote a coordinated and collaborative approach, especially to improving the health of women and children.

INTRODUCTION

In 1994, Congress was considering legislation to reform the U.S. health care system, but chose to defer action on it until next year. If Congress does enact health care reform legislation next year, it could change the way health care is financed and delivered. A critical concern for many people is how a reformed system will balance issues of cost-containment and quality of care, particularly for women and children. The risk that cost-containment programs may create incentives for underservice touches everyone, but may be especially worrisome for those disadvantaged by their economic status or special health care requirements.

Because of a long-standing interest in the health and well-being of women and children, the IOM and the NRC held an invitational workshop on July 7–8, 1994, to address the unique health care requirements of women and children in the context of health care reform. This

brief report, prepared under the guidance of the workshop steering committee, highlights the major points raised in presentations and discussions during the first day of the workshop. Issues associated with assessing the quality of children's health care were addressed at length during the second day of the workshop (NRC and IOM, 1994).

Women and children[1] have a great deal at stake in the outcome of health care reform. Workshop participants noted that the report *Including Children and Pregnant Women in Health Care Reform* (NRC and IOM, 1992) continues to be a valuable guide for efforts to achieve adequate health care for women and children. They expressed concern, however, that federal legislation may not ensure universal coverage, that its benefits package may not meet the needs of women and children—particularly those with disabilities—and that key public health and community services have received little attention and funding (Perrin et al., 1994). The public health system (comprising federal, state, and local health departments) provides essential, population-based public health services such as surveillance and vital statistics, epidemic control, and environmental monitoring. In addition, state and local public health departments often provide personal health services such as prenatal care and well-child care, and enabling services such as case management, transportation, and home visiting.

Expanding health insurance coverage is important because women and children are disproportionately represented among the uninsured. Even with recent federally mandated expansions in Medicaid coverage that have offset some of the decreases in private coverage, during 1992, 15 percent of children in the United States (nearly 10 million children) had no health insurance from any source (Employee Benefit Research Institute, 1993; Teitelbaum, 1994). Currently, 40 percent of children are not covered under their parents' employment-based health insurance (Teitelbaum, 1994). In 1991, 6.2 million employed women of childbearing age (ages 18–44) had no health insurance (March of Dimes, 1993).

Lack of health insurance coverage limits access to necessary health services, but workshop discussions emphasized that neither full health insurance coverage nor better benefit packages will meet all of the health care needs of women and children. Adequate support is also needed for the public health and community services that many maternal and child health programs promote. For example, women may need transportation or child care services that enable them to use available prenatal care and reproductive health care services. For children and adolescents, optimal physical and psychosocial development may be encouraged by services such as nutrition programs, protection from intentional and unintentional injuries, mental health programs, health education, and family planning programs. As lawmakers develop legislation for health care reform, they need to be adequately informed not only about the medical care that women and children need, but also about a broad range of beneficial health promotion activities.

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[1]This report refers to women in their childbearing years, especially pregnant women, and children of all ages from infancy through adolescence.

HEALTH CARE NEEDS OF WOMEN, CHILDREN, AND ADOLESCENTS

All Americans have health care requirements that should be met under a reformed health care system. The current national interest in health care reform presents a special opportunity to address the unique health care requirements of women in their childbearing years, children, and adolescents.

Health Care Needs of Women

A growing interest in protecting and promoting the health of women is reflected in such activities as the new women's health research agenda of the National Institutes of Health and the creation of numerous advocacy groups promoting women's health, broadly defined to include medical, psychological, and social dimensions. Workshop discussions highlighted the need that women in their childbearing years, and especially women who are pregnant, have for a wide variety of reproductive health care services in addition to routine medical care and mental health services. Participants indicated that these reproductive health services should include, at a minimum: contraceptive services and supplies; diagnosis and treatment of sexually transmitted diseases; prenatal, intrapartum, and postpartum care; regular breast and pelvic exams (including Pap tests), in accordance with well-recognized periodicity schedules; risk assessment; and adequate education and counselling to support all of these interventions (Klein, 1994).

Many workshop participants supported the view that reproductive health services should also include access to sterilization and abortion without excessive delay. In the case of abortion, delay into the second trimester greatly increases the risk of medical complications. Despite the continuing political controversy that surrounds the inclusion of abortion in a mandated national benefits package, workshop presentations noted that the majority of current commercial indemnity plans already cover both abortion and sterilization as surgical services.

Workshop participants contended that many barriers help to explain the relatively poor pattern of contraceptive use in the United States as compared to several other developed countries. Some people pointed out that many private insurance companies do not provide full coverage for family planning services. For example, cost-sharing requirements—deductibles and co-payments by which a patient and an insurance plan share the cost of services and contraceptives—may, for some women, constitute an important barrier to contraception. Understanding and decreasing barriers to contraceptive use are especially important inasmuch as over half of all pregnancies in the United States are unintended at the time of conception (Forrest, 1994), which contributes to unnecessarily high rates of abortion, as well as to late entry into prenatal care and various poor pregnancy outcomes. Accordingly, workshop participants noted that insurance policies—public or private—should avoid significant co-payments for contraceptive services and supplies.

Barriers to health care for women, especially high-risk women, are not limited to the fields of contraception or reproductive health. Workshop participants noted that a variety of

cultural, financial, and other barriers may impede women's access to health service generally. For example, women (especially young women, who are in their prime childbearing years) are more likely to be un- or underinsured than men because many of them work at jobs that do not provide health insurance benefits, and this affects their ability to secure needed care. Moreover, some recent studies on cardiovascular disease suggest that women are not always provided the same quality of medical care offered to men with the same diagnosis (Wenger et al., 1993).

Health Care Needs of Children

Although most children are fundamentally healthy, they require health care that emphasizes preventive services, such as immunizations, and the monitoring of physical and psychosocial growth and development, with particular attention to sensitive periods in which appropriate care is essential for sound development and progress. In 1991, only 6 percent of children under 18 years of age (3.8 million children) were limited by chronic health conditions in their ability to perform regular activities such as attending school or playing (Newacheck et al., 1994).

Workshop participants noted that even subtle shifts from a child's normal developmental track may have a life-long impact. For example, recurrent otitis media with fluctuating hearing loss has been postulated to be associated with speech and language difficulties during the toddler years. Delays in identifying a problem or in receiving proper treatment can have irreversible consequences that may increase morbidity, mortality, and cost over both the short and long term. For protection of their health and well-being, children depend on their parents and other adults as well as community institutions (including schools) to both detect and manage emerging health problems. The degree of dependency decreases over time, but in large measure children must rely on adults both to provide care that promotes normal development and to recognize disorders and obtain treatment.

Workshop participants noted that optimal health and development for many children requires both medical care and other health and social services to prevent problems and counter the effects of conditions that have an adverse impact on children. Many important health threats to children lie in socioeconomic and environmental factors, such as poverty and community violence, that are not the traditional targets of clinical preventive services. The health care system must often provide acute or chronic care for conditions that stem from injuries, exposure to toxic substances (e.g., lead), or emotional disturbances; these conditions are all highly influenced by social and environmental factors. The design of effective health promotion or primary prevention programs will often require broad environmental and social interventions, along with more traditional medical approaches. For instance, a range of social services may be needed to provide comprehensive care for children with chronic illnesses, to promote a safe home environment or response to certain behavior problems that may not typically be viewed as health related.

Health Care Needs of Adolescents

Adolescence is a unique developmental period that encompasses the biological changes of puberty, along with other psychological, cognitive, and behavioral changes (Irwin, 1993). Adolescents require access not only to medical care for illness and injury but also to family planning services, substance abuse treatment, mental health services, anticipatory guidance, and various informational and educational activities oriented toward the development of positive health behaviors. Some of their health problems arise from risky health behaviors, which increase rates of sexually transmitted diseases, unintended pregnancy, substance abuse, injuries, and violence. Workshop participants noted that many teenagers receive health care at community clinics or through school-based services, which work to promote healthful behavior and to ensure access to health care for all adolescents. Intervening during adolescence provides an opportunity to prevent the onset of health-damaging behavior as well as to introduce and establish healthy new behavior patterns that may span a lifetime.

Adolescents overall use health care services infrequently and are the age group least likely to seek care through office-based settings. They can face numerous barriers to health care: Often teenagers are no longer comfortable seeking care alongside of babies or small children; they may not want to involve their parents in their care; or their care may not be covered by their parents' insurance. Workshop participants noted that because teens face numerous barriers to health care, they need ways to obtain care independently and with a guarantee of confidentiality such that their parents would be notified only when appropriate. They should not be denied care because of an inability to meet cost-sharing obligations, especially in areas such as reproductive health (including contraception and sexually transmitted disease diagnosis and treatment), substance abuse, or mental health, where family support may be particularly difficult to obtain.

HEALTH CARE BENEFITS FOR WOMEN AND CHILDREN

Workshop participants pointed out that there should be continued efforts to design a comprehensive benefits package for women and children in the context of universal health insurance. The discussion of health care benefits for women and children emphasized the need for more attention to family planning services, mental health and substance abuse care, health education and counselling, and services for children with special health care needs such as care coordination, long-term care or home and community-based therapeutic services. Several approaches to benefit design were examined by workshop participants, including benefit packages from several pending congressional health care reform proposals.

The term *benefit* refers to "the amount payable for a loss under specific insurance coverage (indemnity benefits) or as the guarantee that certain services will be paid for (service benefits)" (IOM, 1993b). The United States relies on a system of voluntary employment-based health benefits (private insurance) and government-funded insurance programs (e.g., Medicare and Medicaid). Currently, neither government nor employment-based coverage reaches certain vulnerable populations, such as families whose income exceeds Medicaid limits but who cannot

afford private insurance (IOM, 1993b). Moreover, coverage under private insurance in particular may be less comprehensive than government-funded insurance for certain types of services, such as preventive care, mental health, and family planning services.

Workshop participants agreed that a national benefits package will need to be comprehensive in order for women and children to receive optimal health care. However, it was emphasized that neither broadening access to health insurance nor improving benefits will meet all health care needs of women and children. In particular, participants emphasized that the need for adequate benefits for long-term care and ancillary services such as care coordination is especially important for children with chronic health problems. Several people also noted the importance of having benefits for mental health and substance abuse services.

Legislative proposals for health care reform address coverage of specific health care services (or benefits) in two ways. One approach defines specific services (including the amount, scope, and duration of coverage) in health care reform legislation. Another approach defines a set of covered services or categories in legislation at a general level and identifies an organization or agency, such as a national health benefits board, which will define the amount, scope, and duration of coverage, as well as co-payments for individual services. For example, services covered in some legislative proposals are listed in general categories such as physician and hospital services, prescription drugs, family planning and prenatal care, preventive medicine, mental health and substance abuse services, hospice and home health services, and vision, hearing, and dental care.

An alternative to designing a benefits package was described at the workshop in which benefits are provided to meet individual needs on a case-by-case basis resulting in a clinically-determined benefit, rather than the traditional benefit-driven treatment. For example, some large corporations have negotiated with health maintenance organizations (HMOs) to provide mental health and substance abuse services using this approach. Arbitrary limits on these services were deemed unnecessary and all treatment is managed according to clinical protocols and criteria so that patients are placed in appropriate levels of care according to their specific needs (Abrams, 1993; Digital Equipment Corporation, 1994).

Defining Medical Necessity

Workshop participants stated that the inclusion or exclusion of specific health services from health insurance plans often depends on whether they are designated "medically necessary." Some argued that this term is unclear and can be interpreted in different ways. The IOM (1993a) defines medical necessity as the need for a specific medical service based on clinical expectations that the health benefits of it will outweigh the health risks; the term is sometimes used interchangeably with medical appropriateness. As noted at the workshop, however, the term *medical necessity*, in a legal context, often serves to limit a health plan's contractual obligation to a beneficiary. Standard clauses in health insurance contracts do not state the decision-making criteria that health plans use to determine medical necessity. Some

insurers and health plans may narrowly interpret medical necessity and possibly limit or exclude certain services that could have broader health benefits (Jameson and Wehr, 1993).

Care for all people, not just women and children, may be particularly constrained by narrow interpretation of the concept of medical necessity. Establishment of a pediatric standard of care could possibly ease this problem with regard to children. Three major differences between adults and children provide the rationale for a separate, pediatric standard: (1) developmental vulnerability, (2) dependency, and (3) patterns of illness and injury (see the section on the Health Care Needs of Children). As described at the workshop, a pediatric coverage standard should allow for a balanced determination between the expense of a service and what is medically necessary. The standard of care would include a list of health care services that plans should provide for children and would require that the scope and duration of those services be consistent with children's growth and development, their dependent status, their risk status, and good clinical practice (Jameson and Wehr, 1993).

COORDINATED HEALTH CARE SERVICES FOR WOMEN AND CHILDREN

Participants in the workshop agreed that many old models for health care delivery are no longer adequate and that health care reform needs to promote a coordinated and collaborative approach, especially for maternal and child health programs. Neither the current system for delivering traditional personal health services nor the public health system alone can effectively provide the full range of health services needed by women and children. For example, personal health services are limited in their ability to manage socioeconomic threats to health, violence, or homelessness, and public health services have not traditionally focused on personal health services, including the diagnosis and treatment of most medical illnesses. Workshop participants suggested that effective systems of care ensure collaboration between medical services and education, nutrition, welfare, and public health programs to prevent and monitor health problems. Ensuring optimal pregnancy outcomes, for example, requires a combination of community-based education and nutritional programs prior to and early in pregnancy, medical and monitoring services during pregnancy, adequate social support during and after pregnancy, and access to specialized technologically sophisticated services for high-risk pregnancies and community-based services for normal and high-risk pregnancies. Consequently, many people feel that collaboration between the public health system and providers of personal health services will be necessary to ensure comprehensive health care (Perrin et al., 1992; IOM, 1994a). For example, the effectiveness of traditional pediatric care offered in a doctor's office may be enhanced when combined with school health services and counseling and enabling services such as case management, and periodic home visits.

Access to Health Care

Although access to health care is often equated with insurance coverage, having insurance does not guarantee that people who need services will get them. As defined by the IOM (1993a), "Access is a shorthand term for a broad set of concerns that center on the degree

to which individuals and groups are able to obtain needed services from the medical care system." Even though the number of physicians has grown in recent years, relatively few serve rural or inner city populations and many have been reluctant to accept Medicaid patients. This has created barriers to care for many low-income and uninsured women and children, which in turn has increased their reliance on community health care providers such as hospital clinics, public health clinics, and community and migrant health centers.

Managed-Care Organizations

Cost containment for health care services provided the initial impetus for reforming health care in the United States. In this context, managed care[2] has been suggested as a mechanism to slow the growth of health care costs while improving access and maintaining the quality of health care. Participation in managed care plans has increased tremendously in both the private and public sectors over the past several years, and many states have mandated enrollment of Medicaid recipients in managed care plans.

Workshop participants noted that managed care is here to stay, regardless of the progress of health care reform, and that its presence has implications for access to appropriate health care services, especially for vulnerable populations. Managed care programs—public or private—are not likely to develop community-based preventive services such as social work or to provide comprehensive treatment services for high-risk populations beyond those enrolled in the health plan. Participants stressed the important role of the public health sector to ensure that women and children in general have access to a broad range of programs that will help to promote their appropriate growth, development, and health. Major concerns were raised about the consequences of managed care for Medicaid recipients. Some workshop participants noted that managed care may limit Medicaid patients' access to health care services, particularly as referrals are restricted. Workshop participants suggested that these issues be considered by the federal government when decisions are made regarding Medicaid waivers.

Public Programs for Maternal and Child Health

Federal and state public health programs that serve women and children include Medicaid; the maternal and child health programs of Title V of the Social Security Act (which provides services to low income women and children, including children with special health care needs); the Supplemental Food Program for Women, Infants, and Children; and the

[2]The term *managed care* as defined by the IOM (1993b) is used (a) broadly to describe health care plans that add utilization management features to indemnity-style coverage or (b) more narrowly to identify group or network-based health plans that have explicit criteria for selecting providers and financial incentives for members to use network providers, who generally must cooperate with some form of utilization management. Managed care includes preferred provider organizations (PPOs), individual practice associations (IPAs), and health maintenance organizations (HMOs).

federal family planning program of Title X of the Public Health Service Act (Perrin et al., 1994). Other relevant public health programs include community and migrant health centers and community-based preventive care programs (i.e., immunization programs and lead poisoning prevention programs) sponsored by the Centers for Disease Control (Perrin et al., 1994). Workshop participants expressed deep concern that health care reform should not be allowed to compromise the services currently provided by maternal and child health programs.

Many established public health programs will change appreciably under the current proposals to reshape the health care system. It is not at all clear, however, what the long-term effects of the proposed changes will be on these programs and the populations they serve. In particular, it is very uncertain what relationship the public health programs will have to the managed care organizations that many reform plans propose. Some effort clearly needs to be devoted to understanding how these many disparate pieces will relate to each other under a reformed system and whether or not this new system of programs will be adequately responsive to the needs of women and children.

Workshop participants articulated an important role for maternal and child health programs in the context of comprehensive health care reform. Participants also attempted to define the elements and structures necessary for maternal and child health programs to complement services available through managed care programs or other sources of direct medical care.

Workshop participants suggested that the design of effective health promotion or primary prevention programs will often require broad environmental and social interventions, along with more traditional medical approaches. Even though medical care cannot "cure" social and environmental problems, it can lessen some of the adverse health effects and facilitate access to a variety of other services that can promote better health and development for children. Some services may be available from health care providers, whereas others may be provided by public health agencies, often with federal support such as Maternal and Child Health Block Grant funds. Education and school-based services also make important contributions to a child's health and developmental progress. Community-wide prevention programs extend beyond the clinical setting, such as injury prevention, family violence prevention, or prevention of environmental toxic effects (i.e., lead). Care that involves the family may help to ensure that children have adequate access to preventive health services.

Participants suggested that one way to ensure that children have adequate access to preventive care is through home visiting programs, which provide care that involves the entire family. A home visiting program usually begins during a woman's pregnancy and continues through the first 2 years of her child's life. Home visiting programs have been proven effective in delivering some preventive health services to children and their families, such as infant health and development programs, and in providing mental health and social services (IOM, 1994b; Olds and Kitzman, 1993). These programs have been used primarily for "at-risk" parents, such as those who are poor, young, single, and have little education (NRC, 1993) and for children with developmental delays and chronic health care needs.

A few states are developing integrated approaches to better serve the health care needs of women and children. Workshop participants reported that some states have combined sources of care and funding to create better mental health programs for children and adolescents. For instance, Minnesota recently passed an integrated funding law that allows local agencies to pool local public funds, which are then matched by Medicaid monies to develop children's mental health programs. Ohio has created a program called Ohio Care, in which they are redesigning their Medicaid program to extend health benefits to underserved populations.

Workshop participants agreed that the existing public health system can facilitate the integration and coordination of maternal and child health programs and that collaboration between public health and personal health services providers will be necessary to ensure the availability of comprehensive health care for women and children. Under health care reform, the public health system could monitor providers' compliance with standards of care, investigate circumstances of untoward morbidity, and collect and analyze data on population-based outcomes in maternal and child health. The public health system could also recommend priorities for services to families and facilitate and support outreach and community interactions among health care, education, and social support agencies.

One perspective presented at the workshop is that the public health system should be responsible for ensuring that all women and children have access to primary and preventive health care services (Miller, 1994; IOM, 1988). Although the public health system need not always provide these services directly, it may need to continue to offer health care to those children and families who are not accommodated by the private health care system. Some workshop participants felt that the federal maternal and child health program could be strengthened by providing it with greater administrative visibility and assistance in policy development through the creation of a national advisory board (Miller, 1994).

CONCLUSION

As the U.S. health care system changes, the parts of the system designed for women and children will need to be reorganized before it can operate effectively. Workshop participants agreed that a priority for the maternal and child health community is to set forth a new vision that values programs for children and women and to define a strategy to carry out this vision to improve and advance their health care. Once the national debate over the financing of health insurance is concluded, federal leadership can help define clinical standards for the entire maternal and child health community. Federal leadership could also support creative improvements and redesign efforts that would integrate public and private health programs to provide the best care possible for women and children.

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Appendix

Workshop on Maternal and Child Health Under Health Care Reform
July 7–8, 1994

Speakers

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